Commentary

The role of teams in resolving moral distress in intensive care unit decision-making

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Abstract

Conflicts arise within teams and with family members in end-of-life decision-making in critical care. This creates unnecessary discomfort for all involved, including the patient. Treatment plans driven by crisis open the team up to conflict, fragmented care and a lack of focus on the patient's wishes and realistic medical outcomes. Methods to resolve these issues involve planned ethical reviews and team meetings where open communication, clear plans and involvement in decision-making for all stakeholders occur. In spite of available literature supporting the value of these techniques, patient care teams and families continue to find themselves involved in spiraling conflict, pitting one team against another, placing blame on family members for not accepting decisions made by the team and creating moral conflict for interdisciplinary team members. Through a case presentation, we review processes available to help resolve conflict and to improve outcome.

Keywords critical care, moral distress, physician–nurse relationship, team interaction

Case

Sara, a 23-year-old woman, was admitted to the transplant service with early-onset idiopathic pulmonary fibrosis, neutropenia and anemia. Both her mother and brother were affected with the same disorder. Her mother died several years ago, ventilated in the intensive care unit (ICU); a death Sara describes as horrible. After witnessing the death of her mother, Sara said repeatedly "I will never die that way". As a result she appointed her aunt power of attorney for personal care. Her brother had a successful transplant 3 years ago and is known to the transplant team.

Sara has now deteriorated with possible community-acquired pneumonia (cultures negative to date) and is hypotensive. In discussion with the transplant team Sara says she wants a transplant, but refuses ventilation. Her last words to the ICU team before intubation are: "No don't put the tube down … I don't want it … I don't want to die like my mother … please, no". On the night that Sara's condition deteriorated, the decision to intubate was made by the ICU resident with support from the transplant team.

After 10 days, the patient remains unstable on increasing ventilatory support. The family is insistent on continuing treatment despite the earlier wishes of Sara. The transplant team assures the family that Sara can be maintained indefinitely on ventilation and they can perform the transplant unless she gets an infection. The ICU team is experiencing growing tension, as their efforts to maintain life support are increasingly difficult with little hope of survival. Sara is now on high-frequency oscillating ventilation. The ICU nurses are unclear of the plan as previously policy stipulated that ventilated patients were not transplant candidates. They find the family's expectations of complete recovery unrealistic. They want to know what is realistic to expect.

Introduction

We are faced in critical care with the need to make decisions when every second counts. In the moment, inaction results in death so we err on the side of life. Patients' wishes about degrees of intervention may be clear but are often disregarded by physicians given the uncertainty of predicting critical care outcomes [1]. The aftermath of such immediate

ICU = intensive care unit.

actions can lead patients, families and care providers into a grey area of supporting life where there is increasingly little hope of recovery. The result is a shift towards prolonging death. This situation is found in critical care units around the world. The present case illustrates a situation where treating teams and the family are at odds. Their respective expectations and plans create a situation of moral distress. In the present article, we shall explore how team interaction and communication could be used to improve the outcome for all involved.

Issues

Nurses ask "what are we doing?", "is there any hope?" and "the family thinks she will go home, and is that realistic?". They ask questions about the appropriateness of treatment plans and sometimes feel they are unable to act in the best interest of the patient and family [2]. The issue of futility is complex, and interpretation may involve varying perspectives of ethical principles and values. Some argue that futility can only be determined from a patient-focused perspective after considering what the treatment represents to the patient regardless of medical indication [3].

Results from studies indicate some physicians have difficulty in accepting that not all treatment can or should be instituted. And not all physicians involved in a particular case agree with an aggressive treatment plan [4]. The concept of withdrawing life support after it has been started is difficult for families and some care providers to accept. Disagreements in life support treatment plans can result in moral distress among care providers. This can have a detrimental impact on the family, especially if their opinions regarding life support are different from the treating team. The cycle of blame and unyielding applications of salvage treatments take the place of open communication and clear plans.

Another approach

In the moment, decisions need to be made quickly. Later, between crises, review of the overall treatment plan is both possible and desirable. Creating a process for regular interdisciplinary team reviews of the patient's progress with input from all those involved in the care, including the family, serves several purposes. First, the team has an opportunity to take a step back and see the big picture. Hearing from each member of the team helps to give a broader framework for decision-making. Instead of dealing with a series of crises, the team is able to look at overall continuity and expectations. Members of the team who are unclear about a realistic prognosis can ask questions to gain understanding. Some teams may be reluctant to join such meetings at first. However, making them mandatory for all long-term cases would have a positive impact on patient care and on team cohesiveness.

The family benefits by feeling that their perspective is heard and valued. Furthermore, they benefit from hearing the full story. Too often, in dealing with one problem at a time, families and other team members lose track of the patient.

A further benefit is the development of trust among team members. The sharing of perspectives can garner support for those unable to stop treatment and for those uncomfortable with the level of uncertainty in the prognosis. This open dialogue provides a vehicle for resolution of polarity in differing perspectives.

Another resource available to teams is an ethics review. In qualitative studies, resolution of lack of consensus was facilitated through use of this process with consistent decreases in medical interventions [5]. Furthermore, a proactive approach resolves conflicts earlier with less harm to all involved.

Conclusion

The necessity of immediate decisions in critical care often results in cases where, upon reflection, different decisions might be made. Mechanisms through which teams can discuss differences and create clarity around treatment rationales will therefore improve team function. The development of interdisciplinary trust and a cohesive plan of care create a more stable and consistent environment for the family and for the patient. Ethical reviews support the team in situations of conflict, and in decisions where appropriate withholding or withdrawing of treatment is necessary.

Following 14 days of ICU care, Sara received a transplant. She died 10 days later following a cardiac arrest on extracorporeal membrane oxygenation and continuous veno-venous hemodialysis without receiving any palliative care.

Competing interests

None declared.

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